

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0025577</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Covenant Health Care Center Batavia</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>02/01/02</u> to <u>01/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>831 North Batavia Avenue</u> <u>Batavia</u> <u>60510</u> <div style="display: flex; justify-content: space-between; width: 100%;"> Number City Zip Code </div>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Kane</u>		Officer or Administrator of Provider	
Telephone Number: <u>(630) 879-4300</u> Fax # <u>(630) 879-8483</u>		(Signed) _____ (Date) _____	
IDPA ID Number: <u>52-11158-73002</u>		(Type or Print Name) <u>Richard W. Olson</u>	
Date of Initial License for Current Owners: <u>05/09/80</u>		(Title) <u>Vice President, Finance</u>	
Type of Ownership:		(Signed) <u>See attached Accountant's Report</u> (Date) _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust		<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
IRS Exemption Code <u>501 (C)(3)</u>		<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	
In the event there are further questions about this report, please contact: Name: <u>Barry C. Scuttillo, CPA</u> Telephone Number: <u>(954) 721-5222</u>		Paid Preparer (Print Name and Title) <u>Scuttillo Blake McMillan & Joyce, PA</u> (Firm Name & Address) <u>8000 North University Drive, Fort Lauderdale, FL 33321</u> (Telephone) <u>(954) 721-5222</u> Fax # <u>(954) 722-6692</u>	
		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Covenant Health Care Center Batavia# 0025577 Report Period Beginning: 02/01/02 Ending: 01/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>128</u>	Skilled (SNF)	<u>122</u>	<u>44,530</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>49</u>	Sheltered Care (SC)		<u>0</u>	5
6		ICF/DD 16 or Less			6
7	<u>177</u>	TOTALS	<u>122</u>	<u>44,530</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,610</u>	<u>28</u>	<u>1,166</u>	<u>2,804</u>	8
9	SNF/PED					9
10	ICF		<u>24,264</u>	<u>9,504</u>	<u>33,768</u>	10
11	ICF/DD					11
12	SC		<u>6,724</u>		<u>6,724</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,610</u>	<u>31,016</u>	<u>10,670</u>	<u>43,296</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 97.23%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/06/80

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 122 and days of care provided 1,610Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 01/31/03 Fiscal Year: 01/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Covenant Health Care Center Batavia # 0025577 Report Period Beginning: 02/01/02 Ending: 01/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	408,752	32,118	2,648	443,518		443,518		443,518			1
2	Food Purchase		277,700		277,700		277,700		277,700			2
3	Housekeeping	190,121	30,589	3,351	224,061		224,061		224,061			3
4	Laundry	53,022	3,489	47,790	104,301		104,301		104,301			4
5	Heat and Other Utilities			178,745	178,745		178,745		178,745			5
6	Maintenance	104,832	24,550	104,977	234,359		234,359		234,359			6
7	Other (specify):*			63,137	63,137		63,137		63,137			7
8	TOTAL General Services	756,727	368,446	400,648	1,525,821		1,525,821		1,525,821			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,518,423	172,403	22,590	2,713,416		2,713,416		2,713,416			10
10a	Therapy		633	29,378	30,011		30,011		30,011			10a
11	Activities	187,550	5,569	49,147	242,266		242,266	(5,463)	236,803			11
12	Social Services	90,526	150		90,676		90,676		90,676			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,796,499	178,755	113,115	3,088,369		3,088,369	(5,463)	3,082,906			16
	C. General Administration											
17	Administrative	150,093		340,042	490,135	(23,711)	466,424	93,120	559,544			17
18	Directors Fees											18
19	Professional Services			46,360	46,360		46,360		46,360			19
20	Dues, Fees, Subscriptions & Promotions			16,900	16,900		16,900	(9,532)	7,368			20
21	Clerical & General Office Expenses	271,948	23,064	72,070	367,082		367,082	(54,015)	313,067			21
22	Employee Benefits & Payroll Taxes			802,013	802,013	23,711	825,724		825,724			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,263	8,263		8,263	(4,353)	3,910			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			81,252	81,252		81,252		81,252			26
27	Other (specify):*											27
28	TOTAL General Administration	422,041	23,064	1,366,900	1,812,005		1,812,005	25,220	1,837,225			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,975,267	570,265	1,880,663	6,426,195		6,426,195	19,757	6,445,952			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Covenant Health Care Center Batavia

#0025577

Report Period Beginning:

02/01/02

Ending:

01/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			608,400	608,400		608,400	(373,155)	235,245			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			861,497	861,497		861,497	(845,363)	16,134			32
33	Real Estate Taxes			16,326	16,326		16,326	(16,326)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,644	2,644		2,644		2,644			35
36	Other (specify):*											36
37	TOTAL Ownership			1,488,867	1,488,867		1,488,867	(1,234,844)	254,023			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	67,104	340,051	24,265	431,420		431,420		431,420			39
40	Barber and Beauty Shops			49,537	49,537		49,537		49,537			40
41	Coffee and Gift Shops		444		444		444		444			41
42	Provider Participation Fee							68,505	68,505			42
43	Other (specify):*	(57)	335	28,722	29,000		29,000	(29,000)				43
44	TOTAL Special Cost Centers	67,047	340,830	102,524	510,401		510,401	39,505	549,906			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,042,314	911,095	3,472,054	8,425,463		8,425,463	(1,175,582)	7,249,881			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Covenant Health Care Center Batavia

0025577

Report Period Beginning: 02/01/02

Ending: 01/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,818)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(373,155)	30		9
10	Interest and Other Investment Income	(861,497)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(166)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(92,571)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,337,207)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	93,120		34
35	Other- Attach Schedule Provider Part. Fee	68,505	42	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 161,625		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,175,582)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Covenant Health Care Center Batavia

ID# 0025577

Report Period Beginning: 02/01/02

Ending: 01/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending, Personal Service, Other Operating Rev	\$ (44,031)	21	1
2	Transportation Revenue Offset	(3,002)	11	2
3	Emp. Recognition, Marketing Exp, Bad Debt	(29,000)	43	3
4	Flowers, Cable TV Access	(2,461)	11	4
5	Dues, Subscriptions, Public Relations	(9,532)	20	5
6	Travel & Seminar	(4,353)	24	6
7	Amortize Loss on Early Retirement of Debt	16,134	32	7
8	Real Estate Taxes	(16,326)	33	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(92,571)		49

Summary A

0025577

Report Period Beginning:

02/01/02

Ending:

01/31/03

[illegible]

Facility Name & ID Number Covenant Health Care Center Batavia# 0025577

Report Period Beginning:

02/01/02

Ending:

01/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Retirement Communities	100%	See attached Schedule	Various	Cov Retire. Comm	Chicago	Mgt Services

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Services	\$ 340,042	Covenant Retirement Communities, Inc.	100.00%	\$ 433,162	\$ 93,120	1
2	V	19 Consulting Services	46,360	Covenant Retirement Communities, Inc.	100.00%		(46,360)	2
3	V	Detail:						3
4	V	19 Data Processing Service				20,448	20,448	4
5	V	19 Audit Service				11,184	11,184	5
6	V	19 Cost Report Preparation				5,855	5,855	6
7	V	19 Payroll Processing				8,873	8,873	7
8	V							8
9	V	22 Pension	6,324	Covenant Retirement Communities, Inc.	100.00%	6,324		9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 392,726			\$ 485,846	\$ * 93,120	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Covenant Health Care Center Batavia # 0025577 Report Period Beginning: 02/01/02 Ending: 01/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Covenant Health Care Center Batavia # 0025577 Report Period Beginning: 02/01/02 Ending: 01/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Covenant Retirement Communities, Inc.
 Street Address 5115 N. Francisco Ave., Suite 200
 City / State / Zip Code Chicago, Illinois 60625
 Phone Number (773) 878-2294
 Fax Number (773) 878-2289

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Management Fees	Net Service Revenue	109,686,000	32	\$ 5,999,907	\$ 1,757,159	5,175,230	\$ 340,042
2									
3	19	Data Processing	Fixed Fee Per Mo (1)	32	32	806,545	Not Available	1	20,448
4	19	Auditing Services	Fixed Fee Per Mo (2)	32	32	330,065	0	1	11,184
5	19	Cost Report Preparation	Fixed Fee Per Mo (3)	14	14	65,714	0	1	5,855
6	19	Payroll Services	Dir. Cost From Vendor	1	1	8,873	0	1	8,873
7									
8	22	Pension Expense	Fixed Fee Per Mo (4)	32	32	152,213	0	1	6,324
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21		(1) Data processing is based upon a fixed fee of \$1,812 per month.							
22		(2) Auditing services are based upon a fixed fee of \$605 per month.							
23		(3) Cost report preparation services are based upon a fixed fee of \$495 per month.							
24		(4) Pension Plan expenses are based upon an estimated fee of \$484 per month.							
25	TOTALS				\$ 7,363,317	\$ 1,757,159		\$ 392,726	

(1) Data processing is based upon a fixed fee of \$1,812 per month.

(2) Auditing services are based upon a fixed fee of \$605 per month.

(3) Cost report preparation services are based upon a fixed fee of \$495 per month.

(4) Pension Plan expenses are based upon an estimated fee of \$484 per month.

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	See Supplemental Schedule 1						\$	34,433,240	\$	28,247,821		\$	1,095,295	1	
2	see Supplemental Schedule 11							1,517,482		1,405,337			248,966	2	
3														3	
4														4	
5														5	
	Working Capital														
6	Interco Notes To/From CRC	XX		Working Capital				(3,959,933)		(2,554,802)	n/a	variable		6	
7														7	
8														8	
9	TOTAL Facility Related						\$	31,990,789	\$	27,098,356			\$	1,344,261	9
	B. Non-Facility Related*														
10	Interest Income Offset												(861,497)	10	
11														11	
12	Amort of Loss on EE of Debt												16,134	12	
13														13	
14	TOTAL Non-Facility Related						\$		\$				\$	(845,363)	14
15	TOTALS (line 9+line14)						\$	31,990,789	\$	27,098,356			\$	498,898	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Health Care Center Batavia COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0025577

CONTACT PERSON REGARDING THIS REPORT Barry Scuttilo, CPA

TELEPHONE (954) 721 - 5222 FAX #: (954) 722 - 6692

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>12-15-177-012</u>	<u>Covenant Health Care Center, Inc.</u>	\$ <u>16,326.00</u>	\$ <u>16,326.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>16,326.00</u>	\$ <u>16,326.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES XX NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:

36,884

B. General Construction Type:

Exterior

Masonry - Brick

Frame

Number of Stories

C. Does the Operating Entity?

☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

The Homstad is a residential independent living facility for senior adults:302,869 square feet and 318 units.

Park Manor is a division of the residential independent living facility which has assisted services for senior adults: 44 out of 64 apartments in Building F

Colonial House is a sheltered care facility licensed for 49 beds; 29,647 square feet and 27 rooms. This facility was closed as of October 2002.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1979-1980	\$ 86,624	1
2					2
3	TOTALS			\$ 86,624	3

Facility Name & ID Number Covenant Health Care Center Batavia

0025577

Report Period Beginning:

02/01/02

Ending:

01/31/03

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	122		1980	1980	\$ 2,454,000	\$ 152,776	33	\$ 74,364	\$ (78,412)	\$ 1,672,818	4
5			2002	2002	4,223,724	52,797	40	52,797		52,797	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Michealsen			1982	8,904	290	30	297	7	5,886	9
10				1983	17,320	1,064	30	577	(487)	11,018	10
11				1984	1,040		10			1,040	11
12				1988	9,128		10			9,128	12
13				1989	18,984		10			18,984	13
14				1990	40,083		10			40,083	14
15				1991	18,354	1,836	10		(1,836)	18,354	15
16				1992	18,931	3,786	10	947	(2,839)	18,931	16
17				1993	90,076	9,008	10	9,008		85,576	17
18				1994	56,935	5,694	10	5,694		49,399	18
19				1995	84,370	8,438	10	8,438		63,285	19
20	Window Treatment			1996	9,675	967	10	967		6,286	20
21	Cubicle Curtain			1997	544	54	10	54		321	21
22	Door			1997	378	38	10	38		207	22
23	Cubicle Curtain			1997	3,495	350	10	350		1,794	23
24	Cubicle Curtain			1997	153	15	10	15		89	24
25	Locks for Lockers			1998	1,514	151	10	151		755	25
26	Awnings for Patio			1998	1,428	143	10	143		641	26
27	Awnings for Patio			1998	1,428	143	10	143		620	27
28	Café Wallpaper			1998	852	85	10	85		372	28
29	Permit for UST Installation			1998	528	53	10	53		225	29
30	Kitchen Renovation			1999	912	91	10	91		360	30
31	Kitchen Renovation-Counter			1999	1,269	127	10	127		452	31
32	Awnings			1999	938	94	10	94		316	32
33	Awnings			1999	938	94	10	94		308	33
34	Smoking Area Receptacles			1999	467	47	10	47		153	34
35	Window Cornice			1999	569	57	10	57		186	35
36	Counters & Sinks			2000	2,810	281	10	281		830	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	6 Wire Shelf Truck	2000	\$ 1,002	\$ 100	10	\$ 100		\$ 292	37
38	Ceiling Fans	2000	1,870	187	10	187		491	38
39	Door Lock	2000	1,532	153	10	153		381	39
40	Roof Repair	2000	2,597	260	10	260		564	40
41	Chapel Architect Services	2002	1,541		20	39	39	39	41
42									42
43									43
44	Building Improvements-Colonial House								44
45	Improvements	2002	1,325	33	20	33		33	45
46									46
47									47
48									48
49									49
50	Adjustment for disposal of building			292,859			(292,859)		50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,079,614	\$ 532,071		\$ 155,684	\$ (376,387)	\$ 2,063,014	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward	\$ 7,079,614	\$ 532,071		\$ 155,684	\$ (376,387)	\$ 2,063,014	1
2								2
3	Land Improvements-Michealsen	1982 780		20 39	39	770		3
4		1986 14,644		20 732	732	12,380		4
5		1987 12,022		20 601	601	9,728		5
6		1988 1,368	68	20 68	68	1,080		6
7		1989 520	32	20 26	(6)	390		7
8		1989 17,748	827	20 888	61	11,988		8
9		1990 4,592	155	20 230	75	2,875		9
10		1991 11,423	697	20 571	(126)	6,567		10
11								11
12	Land Improvements-Colonial House	1990 3,528	176	20 177	1	2,384		12
13		1991 2,508	125	20 125		1,566		13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 7,148,747	\$ 534,151		\$ 159,141	\$ (375,010)	\$ 2,112,742	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 654,603	\$ 61,940	\$ 63,795	\$ 1,855		\$ 283,223	71
72	Current Year Purchases	246,178	12,309	12,309			12,309	72
73	Fully Depreciated Assets	466,591					466,591	73
74								74
75	TOTALS	\$ 1,367,372	\$ 74,249	\$ 76,104	\$ 1,855		\$ 762,123	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,602,743	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 608,400	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 235,245	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (373,155)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,874,865	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 2,644 Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A	103 hrs	\$ 3,116	251	\$ 15,509	\$	354	\$ 18,625	1
2	Licensed Speech and Language Development Therapist	10A	hrs		96	6,542		96	6,542	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	2056 hrs	63,989	10	601		2,066	64,590	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescripts		17,099	339,338		17,099	339,338	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39								13
14	TOTAL			\$ 67,105	17,456	\$ 361,990	\$	19,615	\$ 429,095	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 962,461	\$ 6,198,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	583,755	8,345,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		11,056,000	5
6	Prepaid Insurance	5,470		6
7	Other Prepaid Expenses		3,055,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,551,686	\$ 28,654,000	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		76,199,000	12
13	Land	127,368	17,211,000	13
14	Buildings, at Historical Cost	7,190,246	403,309,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	872,497	51,615,000	16
17	Accumulated Depreciation (book methods)	(2,428,513)	(155,950,000)	17
18	Deferred Charges	995,838		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	6,815,903	86,141,000	21
22	Other Long-Term Assets (specify):		24,851,000	22
23	Other(specify): <u>Constuction in Progress</u>	7,453,423	26,846,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,026,762	\$ 530,222,000	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 22,578,448	\$ 558,876,000	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 346,801	\$ 7,264,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		3,654,000	28
29	Short-Term Notes Payable		500,000	29
30	Accrued Salaries Payable	215,149	3,178,000	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,602		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,655		32
33	Accrued Interest Payable	199,328	2,530,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	11,019	3,214,000	36
37	<u>Current Maturities, LTD</u>	146,641	4,446,000	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 950,195	\$ 24,786,000	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	18,685,180		40
41	Bonds Payable		277,972,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Accts, Other Liabilities</u>	(2,461,133)	16,336,000	43
44	<u>Deferred Revenue</u>		189,913,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 16,224,047	\$ 484,221,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 17,174,242	\$ 509,007,000	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,404,206	\$ 49,869,000	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 22,578,448	\$ 558,876,000	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,442,355	1
2	Restatements (describe):		2
3	Adjustment to exclude results of Private facility	7,151	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,449,506	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(45,300)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (45,300)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,404,206	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,336,847	1
2	Discounts and Allowances for all Levels	(1,021,214)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,315,633	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	190,969	6
7	Oxygen	13,230	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 204,199	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	56,277	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	9,818	15
16	Rental of Facility Space		16
17	Sale of Drugs	379,508	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,804	19
20	Radiology and X-Ray		20
21	Other Medical Services	176,380	21
22	Laundry	78,957	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 740,744	23
	D. Non-Operating Revenue		
24	Contributions	24,046	24
25	Interest and Other Investment Income***	1,027,023	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,051,069	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Equipment Rental</u>	21,485	28
28a	<u>See attached list</u>	47,033	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 68,518	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,380,163	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,525,821	31
32	Health Care	3,088,369	32
33	General Administration	1,812,005	33
	B. Capital Expense		
34	Ownership	1,488,867	34
	C. Ancillary Expense		
35	Special Cost Centers	510,401	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,425,463	40
41	Income before Income Taxes (line 30 minus line 40)**	(45,300)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (45,300)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Covenant Health Care Center Batavia# 0025577Report Period Beginning: 02/01/02Ending: 01/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,824	2,080	\$ 70,600	\$ 33.94	1
2	Assistant Director of Nursing	10,241	10,897	282,797	25.95	2
3	Registered Nurses	45,175	51,817	1,018,853	19.66	3
4	Licensed Practical Nurses	2,763	3,076	60,214	19.58	4
5	Nurse Aides & Orderlies	72,580	80,120	1,021,384	12.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,159	2,387	67,105	28.11	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,662	3,184	46,407	14.58	9
10	Activity Assistants	7,281	9,868	125,286	12.70	10
11	Social Service Workers	4,487	5,746	90,525	15.75	11
12	Dietician					12
13	Food Service Supervisor	4,227	5,723	108,591	18.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,943	29,672	300,161	10.12	15
16	Dishwashers					16
17	Maintenance Workers	4,524	5,581	104,832	18.78	17
18	Housekeepers	18,053	19,336	190,121	9.83	18
19	Laundry	6,510	8,657	53,022	6.12	19
20	Administrator	2,876	3,308	150,094	45.37	20
21	Assistant Administrator					21
22	Other Administrative	2,986	3,798	63,704	16.77	22
23	Office Manager	2,195	2,317	37,129	16.02	23
24	Clerical	9,457	10,675	171,057	16.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,672	2,070	31,292	15.12	31
32	Other Health Care(specify)					32
33	Other(specify)	3,237	4,239	49,140	11.59	33
34	TOTAL (lines 1 - 33)	231,852	264,551	\$ 4,042,314 *	\$ 15.28	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	87	\$ 2,652	Ln 1, Col 3	35
36	Medical Director	monthly	9,840	Ln 9, Col 3	36
37	Medical Records Consultant	75	2,885	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,317	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	162	\$ 16,694		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	475	11,595	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	475	\$ 11,595		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%			Description			Description			
Karen Larson	Administrator	0%	\$	37,209	Workers' Compensation Insurance	\$	133,692	IDPH License Fee	\$		
John Currier	Administrator	0%		12,962	Unemployment Compensation Insurance		23,633	Advertising: Employee Recruitment		7,368	
Susan Graunke	Administrator	0%		76,211	FICA Taxes		288,695	Health Care Worker Background Check (Indicate # of checks performed _____)			
					Employee Health Insurance		320,030	Promotion/Public Relations		1,590	
Add: Reclass Fringe Benefits				23,711	Employee Meals			Dues & Subscriptions		7,942	
					Illinois Municipal Retirement Fund (IMRF)*			Less: Unallowable Dues/Subscriptions		(7,942)	
					Group Life Insurance		14,185				
					Pension Plan		6,423	Less: Public Relations Expense		(1,590)	
					Other		15,455	Non-allowable advertising ()			
								Yellow page advertising ()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	150,093				TOTAL (agree to Sch. V, line 20, col. 8)	\$	7,368	
B. Administrative - Other					Reclass Administrator Fringe Benefits			23,711			
Description			Amount		TOTAL (agree to Schedule V, line 22, col.8)			\$	825,824		
Covenant Retirement Communities, Inc.			\$	340,042							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	340,042	E. Schedule of Non-Cash Compensation Paid to Owners or Employees						
C. Professional Services					Description	Line #	Amount	G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount					Description		Amount	
Deloitte & Touche	Auditing Services		\$	11,184				Out-of-State Travel	\$	1,835	
A.D.P	Payroll Services			8,873				Unallowable Out of State Travel		(1,835)	
Covenant Retire. Comm.	Data Processing Services			20,448							
Scuttillo Blake McMillan & Joyce, PA	Cost Report Prep			5,855				In-State Travel		1,340	
								Unallowable In-State Travel		(574)	
								Seminar Expense		5,088	
								Unallowable Seminar Expense		(1,944)	
								Entertainment Expense ()			
								(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$	46,360	TOTAL			\$	3,910		

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Covenant Health Care Center Batavia

STATE OF ILLINOIS

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$5,681
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 67,151 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES XX NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO XX If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 68,505
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,562
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Deloitte & Touche LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.